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ONE HUNDRED SEVENTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE
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February 26, 2021

Clay Marsh, M.D.
West Virginia COVID-19/Coronavirus Czar
P.O. Box 9000
1 Medical Center Drive
1000 Health Sciences South
Morgantown, WV 26506

Dear Dr. Marsh:

Thank you for appearing before the Subcommittee on Oversight and Investigations on Tuesday, February 2, 2021, at the hearing entitled "No Time to Lose: Solutions to Increase COVID-19 Vaccinations in the States." I appreciate the time and effort you gave as a witness before the Committee on Energy and Commerce.

Pursuant to Rule 3 of the Committee on Energy and Commerce, members are permitted to submit additional questions to the witnesses for their responses, which will be included in the hearing record. Attached are questions directed to you from certain members of the Committee. In preparing your answers to these questions, please address your response to the member who has submitted the questions in the space provided.

To facilitate the printing of the hearing record, please submit your responses to these questions no later than the close of business on Friday, March 12, 2021. As previously noted, this transmittal letter and your responses, as well as the responses from the other witnesses appearing at the hearing, will all be included in the hearing record. Your written responses should be transmitted by e-mail in the Word document provided to Austin Flack, Policy Analyst, at austin.flack@mail.house.gov. To help in maintaining the proper format for hearing records, please use the document provided to complete your responses.

Thank you for your prompt attention to this request. If you need additional information or have other questions, please contact Austin Flack with the Committee staff at (202) 225-2927.

Sincerely,

Frank Pallone, Jr.
Chairman

Attachment

cc: The Honorable Cathy McMorris Rodgers
Ranking Member
Committee on Energy and Commerce

The Honorable Diana DeGette
Chair
Subcommittee on Oversight and Investigations

The Honorable Morgan Griffith
Ranking Member
Subcommittee on Oversight and Investigations

Attachment—Additional Questions for the Record

Subcommittee on Oversight and Investigations
Hearing on
"No Time to Lose: Solutions to Increase COVID-19 Vaccinations in the States"
February 2, 2021

Clay Marsh, M.D., West Virginia COVID-19/Coronavirus Czar

The Honorable Frank Pallone, Jr. (D-NJ)

1. Do you believe there are other ways communication and coordination around states' vaccine orders and federal government allocation and shipping could be improved?

   The consistency and accuracy of the weekly federal vaccine supply to states has stabilized as has the accurate projection of additional vaccine doses over time. This is an improvement that correlates with a more predictable and mature vaccine production line. In West Virginia, we have been among the best states in the nation in using our weekly inventory, and we appreciate being supplied with additional doses that we are using in a highly disciplined vaccination priority basis to immunize our oldest and most vulnerable population. To date, we have seen an 85% reduction in deaths over the first 7 weeks of 2021, along with a 75% reduction in hospitalizations and marked reduction in ICU admissions for COVID-19.

The Honorable Kathleen Rice (D- NY)

1. How do adolescents – those currently able to receive the Pfizer vaccine – and specifically adolescents with complex medical needs fit into your state's vaccine distribution plans?

   How do families and caregivers of children with medical complexity fit into your distribution plans?

   a. Once a vaccine is safe and effective for younger children, what are your plans for distribution and administration of vaccine doses for this population?

      In West Virginia, we have prioritized saving lives and preserving health and hospital bed capacity as our central target of our vaccination priority. As such, we identified that our average age of death from COVID-19 is 77; 77.5% of deaths in West Virginia are in citizens aged 70 and older; 92% of deaths in West Virginia are in those 60 and older; and 97% of deaths in West Virginia occur in those aged 60 and older. Half of our deaths were from nursing home residents. With our focus, we were the first in the country to immunize our nursing home population and currently have immunized about 160,000/350,000 over age 65 with one dose and 80,000 with two doses. We have recently included those with co-morbidities, including caregivers of children that need chronic care and those 16 and older who are at high risk for COVID-19 severity (Down syndrome; sickle cell anemia;

cystic fibrosis; congenital or acquired disability needing chronic caregiving; solid organ transplant) in our priority phase. These individuals are currently being served through doses available at pharmacies via the Federal Pharmacy Partnership and the state's community clinic model.

a) We will continue our priority scheme directed at saving lives and reducing hospitalizations. Thus, our older West Virginia residents and those with high-risk co-morbid disease will be prioritized for vaccination. As vaccine supply increases, we will turn to WV in critical workforce jobs, like education professionals, to be vaccinated at all ages. As we continue to fully immunize teachers and service personnel in schools, we await data being generated now to assess the safety and efficacy of vaccinating younger residents. Currently, Pfizer is approved for those aged 16 and older and Moderna/J&J for those aged 18 and older.

The Honorable Morgan Griffith (R-VA)

1. Are you aware of the COVID emPOWER program that permits identifying the Medicare beneficiaries who are at greatest risk for hospitalization and death from COVID?

    a. If so, are you using this program to help identify and vaccinate those at greatest risk?

    HHS emPOWER is a powerful tool, but to date, we have not used it in West Virginia to contact the Medicare population. We have relied on self-registration, vaccination of all nursing home and assisted living residents, and for those aged 65 and older via their primary care practices and health system rosters to reach out to our most vulnerable population. With this question, we are now looking at this resource, too.

2. According to The Washington Post, tens of thousands of Americans with intellectual and developmental disabilities — who are two to three times as likely to die of COVID-19 — are waiting for an answer to when they will receive a COVID-19 vaccine.[1] Disability advocates say guidance should be interpreted to include all people with disabilities who receive long-term care, whether in large institutions, or in smaller group homes. Most states make no mention of disabilities in their vaccine plans, leaving people confused about how long they and those for whom they care will have to wait. How do you plan to inoculate this group of individuals?

    a. Since this group of individuals may not be able to independently access the state's current information and scheduling portals, what type of avenues will your state use to notify people with disabilities when they become eligible and offer them assistance when booking appointments?

As indicted, we have included these West Virginia individuals and their caregivers in our most recent priority vaccination guidelines. We are working with the DHHR, medical systems, primary care networks, Center for Excellence in Disabilities (at West Virginia University), West Virginia Fair Shake Network and other volunteer advocacy efforts on behalf of disabled individuals and their caregivers. Appointments

can be arranged by their advocates/families/caregivers by calling our hotline number for vaccinations and efforts are also underway to bring vaccines to those living in congregate settings with approval for vaccination. We are also partnering with pharmacies and IDD waiver program to administer vaccine on site at congregate care settings.

3. One of the issues we are hearing about as the vaccination campaign unfolds is the difficulty some non-hospital-based health care providers are having in accessing the vaccine for their staff. In some states, the rollout for health care providers does seem to be going relatively smoothly. However, in others, it is a real struggle. Employers are not able to help sign their health care workers up for vaccinations. Instead, employees have to navigate an ad hoc system on their own without any centralized access point. Depending on local distribution realities, these health care providers are told to check with county health departments, to sign up on state websites, or to call local hospitals. Sometimes it works, sometimes it doesn't.

   Health care providers are on the front lines, not only as it relates to exposure but also as potential spreaders of infection to the patients they serve, many in home settings. We have to figure this out and we need to act quickly.

   The federal government has contracted with CVS and Walgreens to make COVID-19 vaccines available to nursing home patients and staff. Would it make sense to expand this contract, or set up additional contracts with national health care providers, to permit other patient facing health care workers organized and predictable access to the vaccine?

   West Virginia uses an interagency approach to identify healthcare workers eligible for vaccinations that include sector experts in areas of hospital, outpatient and home health fields. We have extensively immunized front-line hospital workers and staff and primary care providers. We have delineated home health workers, hospice, physical/occupational/speech therapists as essential workers and have vaccinated those aged 50 and older as part of our Phase 1-C priority and are now anticipating expanding access to those aged 50 and older as more vaccines become available. We have used a state registration system to identify these individuals but are working closely with our Federal pharmacy program recipients to continue to identify and immunize these essential workers.

4. How does your state plan to use the funding from the recent stimulus package to secure surge resources to help improve vaccine administration in your state?

   We continue to train and hire staff to expand our vaccination capacity. In addition, we have also focused on improving the supply chain in West Virginia to include purchase and replacement of any needle/syringe in ancillary kits that do not contain low dead-space syringes to gain the sixth dose from Pfizer and also extra doses from Moderna and J&J. Additional uses of the recent stimulus funding is to maintain individuals at the state level for expanded IT functions, like vaccine tracking, distribution, projecting doses for individual clinics and for extended National Guard personnel focusing on transport, supply chain handling and storage of vaccines. In West Virginia, we also expanded free testing to all state residents, including higher education, and PPE for front-line and essential workers, teachers, school service personnel and for home health

providers.

5. What is your state's strategy to reach the level of immunization needed for herd immunity?

    a. What evidence will your state be looking for to determine whether herd immunity has been reached?

    We will monitor transmission rates, hospitalizations, deaths and outbreaks in congregate settings like nursing homes, assisted living facilities and schools. While we have vaccinated about 21% of our population with one shot and completely vaccinated 13%, we have identified the UK variant of COVID-19, as well as the CA variant in West Virginia. Since a state would need to be approximately 75-85% immune for herd immunity with COVID-19 without impact of variant viruses that may evade native or vaccination-associated immunity, we do not think we are at that level yet, despite very favorable reduction in transmission, outbreaks, hospitalization and death over the past 8 weeks.

6. Another tool that is available as we move to vaccinate Americans as quickly as possible – high-quality serology tests. Certain serology tests, called quantitative or semi-quantitative tests, can measure the approximate level of antibodies in a person's body. These tests can be used to track the immune system's response to a COVID-19 vaccine – helping to identify when a booster shot may be needed among other benefits. Are any of your states using, or have you considered using, these high-quality tests as part of your vaccine roll-out and follow-up?

    a. If yes, how are you using the tests?

    This is certainly an aspiration we have for the near future. We are piloting a study in some of our nursing home residents to assess their antibody titers following vaccination, our focus has been solely on acceleration and efficiency around vaccination of our most vulnerable citizens to date.

    b. If no, do you see a benefit to tracking the durability of the immune response, particularly considering some of the mutated strains like those from South Africa, Brazil, or United Kingdom?

    Yes, this is an important issue. One complicating factor is that other parts of our immune system, including T-cell, macrophage and gamma-interferon production may be critical in controlling the severity and risk of death from COVID-19, which are not detected by antibody testing.

7. One of the issues we hear about is the difficulty states and providers are having at the last mile, actually getting shots into arms. Once Phase 1 has been completed, do you agree that we should have an all-hands-on deck approach, using all of America's commercial distribution resources, customer connectivity, expertise and end-to-end logistics across a multitude of provider settings, to ensure the American public has expedited and equitable access to a vaccine once we get to broad distribution?

Yes, the vaccines we have available at record speed are incredibly effective in reducing risk of COVID-19 infection, spread and particularly against hospitalization and death. As vaccines become more plentiful, then all Americans should have broad access. That goes for any additional boost doses that may be needed if variant viruses in the future evade our vaccine-driven immunity.

8. What technologies or other resources is your state using to provide the public with information about COVID-19 vaccines? In particular, how are you connecting with those rural communities, where internet-based communication is often less reliable?

We have multiple means to reach our target populations, including three-times a week updates from Gov. Justice and our leadership team; newspaper; radio; videos; website, information call line, social media and messages from local health departments and over 200 public health partners in the state across various sectors. We partnered with the West Virginia University Public Interest Communication Research Lab and the Center for Rural Health Development to use mixed-methods social science through quantitative inquiry (statewide surveys, particular population surveys, message/appeal testing experiments) and qualitative inquiry (focus groups, in-depth interviews, intercept interviews, direct observation, social sentiment analysis) to identify beliefs, concerns, and perceptions among West Virginians about COVID-19 vaccines to inform development and ongoing evaluation of the statewide COVID-19 Vaccine Communication Campaign. This allows continuous, adaptive data collection across all phases, based on behavior change theory and resources from CDC and others.

The Honorable Michael C. Burgess, M.D. (R-TX)

1. The distribution of the COVID-19 vaccine has highlighted the importance of drug delivery, and the precision and logistics that are required to make it successful. Waste has been a topic of concern lately, with many conversations surrounding the need for low dead-volume syringes to extract the 6th dose from the Pfizer vials. Are there any other causes or contributors to vaccine doses being wasted, and how might these factors be addressed?

I would say that low, dead-volume syringes and appropriate needles are key, but also empowerment of vaccinators and disciplined control of processes that are needed to track vaccine supplies, clarify efficiency of vaccination of all doses and back-up plans if additional doses result from missed appointments or unforeseen circumstance. Our goal is to vaccinate an alternate person who fits the priority guidelines for West Virginia, but in the absence of such an individual, making sure that every shot is used on a West Virginia citizen is critical.

2. On a similar topic of waste, there have been instances of long-term care facilities, or the pharmacies that are helping to administer the vaccines at long-term care facilities, receiving a supply that exceeds demand in these facilities for various reasons. For example, my understanding is that allocations were made to account for 100 percent capacity, yet not all facilities are at 100 percent capacity. Are there guidelines for these facilities and the pharmacies to follow when this happens? Additionally, what do you believe is the most efficient practice for facilities to follow if they have more doses than are needed?

We were one of the few states that did not initiate the federal pharmacy program and instead, received vaccines centrally and used our pre-identified network of small, local and family-owned pharmacies and long-term care facilities to receive just-in-time amounts of vaccine commensurate with the numbers of patients and staff at each facility.

a. How might allocation methodology shift to address this issue for the administration of second doses?

It's important to project increases in numbers of second vaccines so that we can focus on getting as many first vaccines in the arms of our most vulnerable without risking missing second doses.

3. It has been reported that one reason many long-term care facilities have extra doses is due to vaccine hesitancy. Often this hesitancy is even higher among the staff than

the residents. This is an issue of bipartisan concern, as Dr. Schrier and I worked together on the VACCINES Act last Congress. I have heard anecdotally that vaccination rates are getting better among staff when pharmacies return for their second visit at a facility, but more work is needed to reduce vaccine hesitancy overall. What can states and facilities do to address this hesitancy and build trust?

Our initiation with networks of local and family-owned pharmacies reduced vaccine hesitancy and improved the numbers of residents and staff that agreed to vaccination.

4. West Virginia has clearly been successful in distributing the COVID-19 vaccine, with much of this success being an example of states and localities knowing what will work best in their own communities. How can the federal government coordinate better with states without infringing upon flexibility and state control?

This is obviously a decision for each Governor and state leadership team. As stated, we have looked at COVID-19 as a Black Swan event that requires agility, flexibility, rapid learning and a mindset of trial and assessment. We try to identify critical system requirements, reduce bottlenecks, use commander's intent (clarify desired outcomes, facilitate empowerment and creativity of team members to solve this).

[1] *People with disabilities desperately need the vaccine. But states disagree on when they'll get it*, The Washington Post (Jan. 13, 2021).

5. President Biden invoked the Defense Production Act in an effort to increase the supply of materials necessary for COVID-19 vaccination. Regardless of implementing the DPA, there is only so much manufacturing capacity, and we must remain cognizant of the ongoing routine health care. In the event that all supplies are dedicated to COVID-19 vaccination efforts, are there strategies or contingency plans to supply other areas of the market, such as childhood vaccinations, which depend on many of the same supplies used for administering the COVID-19 vaccine?

   An extremely important point. It is also a critical point for post COVID-19 opportunities in public and population health to both ready the United States for the next pandemic, but to also focus on improving the health and well-being of our state and country.

The Honorable Neal P. Dunn, M.D. (R-FL)

1. Given our hope and expectation that states will soon receive larger allocations of vaccines and supplies, I am focused on the need for states to ramp up their vaccine delivery capabilities. In my home state of Florida, for example, private companies are stepping up to make their expertise and resources available for cold chain purposes. I know other companies across various industries are actively working to find ways to lend their expertise. What specific advice or guidance can you offer companies and organizations who want to assist your state with these efforts, cold chain or otherwise?

   This is a critical point, and we need to harvest the capacity and capability of our private business partners but need to also make sure that we are all focusing on the same targets. Alignment on goals to be reached and on processes to avoid duplication of efforts is key. In this way, private industry partners and state agencies need to work in constant and transparent communications (a Team of Team approach) so that parallel structures that produce more bottlenecks are not created. This is where clear state leadership response structure needs to be enhanced with expertise from the private sector, but still move with agility and not be afraid to change together.